Washington State Department of Social & Health Services

CHILDREN'S ADMINISTRATION
MEDICAID TREATMENT CHILD CARE PROGRAM

DCFS SOCIAL WORKER MONTHLY PROGRESS REPORT

PLEASE PRINT CLEARLY

MONTH OF REPORT:	YEAR OF REPORT:		
MTCC CONTRACTED PROVIDER:	MTCC SITE:		
MTCC ADDRESS:			
CONTACT PERSON:	PHONE:		
CHILD'S NAME:		DATE OF BIRTH:	AGE:

Number of days the child was absent this month: _____

Parent met with family counselor at least one time? . . . . . ☐ Yes ☐ No

Parent participated in:

Group interventions with both parent and child? . . . . . ☐ Yes ☐ No

Facilitated group for caregivers (always birth parent of child when family reunification is expected outcome)? . . . . . ☐ Yes ☐ No

Multidisciplinary team meeting? Date: . . . . . ☐ Yes ☐ No

Current treatment goals:

Progress toward meeting treatment goals:

Barriers to meeting treatment goals:

Report from monthly home visit:

Other:

SIGNATURE:	DATE:
PRINTED NAME:	POSITION: